Reset

The STANDARD INSURANCE

Accidental Dismemberment Employer's Statement

Standard Insurance Company, Life Benefits Department
PO Box 2800 Portland OR 97208-2800 800.628.8600 Tel

Please type or print. Form may be returned for unanswered questions.

EMPLOYEE INFORMATION

Full Name: _____

Date of employment or association membership (union or other): _____

Date employee's insurance effective: _____

Employee's status: Actively at Work? ☐ Yes ☐ No

Number of Hours Worked per Week: _____ Last day of work: _____

Is employee now terminated? ☐ Yes ☐ No Date of Termination: _____

Reason: _____

AMOUNT OF INSURANCE

Does employee have group life insurance under more than one policy number? ☐ Yes ☐ No

If yes, list all policy numbers: _____

Amount of Basic Life Insurance $ _____

Amount of Additional Life Insurance $ _____

If life insurance is based on earnings, please check appropriate box and fill in the amount of salary.

- ☐ Basic Monthly Earnings — Monthly rate $_____
- ☐ Basic Yearly Earnings — Annual rate $_____
- ☐ Basic Contract Earnings — Contract amount $ _____ Length of contract: _____
- ☐ Basic Weekly Earnings — Weekly rate $ _____
- ☐ Basic Hourly Earnings — Hourly rate $ _____
- ☐ Commissions (Please attach list of commissions paid for each of last 12 months.)

Insurance Class (Refer to policy schedule of benefits): _____

Amount of benefit being claimed $ _____

Date of last increase in earnings or benefit? _____

Earnings Prior to Increase $ _____ per _____

PREMIUMS

Please advise last month premiums paid: _____

EMPLOYER REPRESENTATIVE COMPLETING THIS FORM

Employer: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone No.: (_____) _____ Policy No.: _____

Acknowledgement

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 4 of this form.

Signature: _____ Title: _____ Date: _____

(Please attach copies of all enrollment cards.)

The STANDARD INSURANCE

Accidental Dismemberment Claim Form Fraud Notices

Standard Insurance Company, Life Benefits Department
PO Box 2800 Portland OR 97208-2800 800.628.8600 Tel

Some states require us to provide the following information to you:

CALIFORNIA RESIDENTS

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO RESIDENTS

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FLORIDA RESIDENTS

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

NEW JERSEY RESIDENTS

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim, containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ALL OTHER APPLICANTS AND CLAIMANTS

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

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